SOUTH DAKOTA DEPARTMENT OF HEALTH
OFFICE OF DISEASE PREVENTION
STD/HIV CONTROL PROGRAM
615 East 4th Street, Pierre, SD 57501

I. AUTHORIZATION

Payment will be made only after prior authorization by the STD Control Project (800-592-1861).

Authorized By:

Name _____ Date __/__/__

II. PATIENT INFORMATION

Chart # _____

Name:_____ Age:_____ Sex: [] Male [] Female

Address:_____ City:

III. MEDICAL INFORMATION

A. Reason for Exam: (Check all that apply.)

[] Symptomatic Contact to: [] Chlamydia [] Gonorrhea [] Syphilis

B. Laboratory Testing: (Check all that apply.)

Note: The STD Project can only pay for STD testing (syphilis serologies, or GC/CT GenProbe tests) submitted to the State Health Laboratory. Please contact us for submission instructions.

Test	Results
Gonorrhea	[] Positive [] Negative
Chlamydia	[] Positive [] Negative
Syphilis Serology	[] Positive [] Negative
Gonorrhea Culture	[] Positive [] Negative

C. Treatment: The following medication was administered and replacement is requested.

Gonorrhea	Chlamydia	Syphilis
[] Ceftriaxone 250 mg IM	[] Doxycycline 100mg BID X 7	[]Benzathine Penicillin
[] Cefixime (Suprax) 400mg	[] EES 500 mg QID X 7	
	[] EES 250 mg QID X 14	
	[] Azithromycin 1 Gm	

[] No Medication Replacement is Requested

IV. REQUEST FOR PAYMENT

I request that the STD Control Project pay a fee of twenty five dollars ($25) for the examination and treatment of an indigent STD patient.

_____ _____ __/__/__

Physician's Name (Please print or type) Signature Date

Clinic Name and Mailing Address